STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF A PETITION FOR DECLARATORY RULING INVOLVING	FINAL DECISION ON PETITIONER'S MOTION FOR SUMMARY JUDGMENT AND FINAL ORDER DISMISSING PETITION FOR DECLARATORY RULING
WISCONSIN SOCIETY OF ANESTHESIOLOGISTS, PETITIONER,	
and	LS0511012MED
GOVERNOR JIM DOYLE, ATTORNEY GENERAL J.B. VAN HOLLEN, CENTERS FOR MEDICARE AND MEDICAID SERVICES, PODIATRISTS AFFILIATED CREDENTIALING BOARD, WISCONSIN ASSOCIATION OF NURSE ANESTHETISTS, WISCONSIN BOARD OF NURSING, WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, WISCONSIN DEPARTMENT OF REGULATION AND LICENSING, WISCONSIN HOSPITAL ASSOCIATION, WISCONSIN MEDICAL SOCIETY, and WISCONSIN SOCIETY OF PODIATRIC MEDICINE,	
INTERESTED PARTIES.	

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 15th day of August, 2007.

Gene Musser MD
Member of the Board
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

In the Matter of a Petition for
Declaratory Ruling involving,

WISCONSIN SOCIETY OF
ANESTHESIOLOGISTS,

PETITIONER,

and

GOVERNOR JIM DOYLE,
ATTORNEY GENERAL J.B. VAN HOLLEN,
CENTERS FOR MEDICARE AND MEDICAID SERVICES,
PODIATRISTS AFFILIATED CREDENTIALING BOARD,
WISCONSIN ASSOCIATION OF NURSE ANESTHETISTS,
WISCONSIN BOARD OF NURSING,
WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES,
WISCONSIN DEPARTMENT OF REGULATION AND LICENSING,
WISCONSIN HOSPITAL ASSOCIATION,
WISCONSIN MEDICAL SOCIETY, and
WISCONSIN SOCIETY OF PODIATRIC MEDICINE,

INTERESTED PARTIES.

PROPOSED DECISION ON PETITIONER'S MOTION FOR SUMMARY JUDGMENT AND PROPOSED ORDER DISMISSING PETITION FOR DECLARATORY RULING

Case No. LS0511012MED

The parties to this action for purposes of Wis. Stat. § 227.53, are:

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INTRODUCTION

The Medical Examining Board decides in this case whether to issue an order declaring that the administration of anesthesia by a certified registered nurse anesthetist (CRNA) must be performed under the supervision of a physician. A CRNA is a nurse licensed as a registered nurse (RN) under Wis. Stat. ch 441 and certified by the American Association of Nurse Anesthetists as a "certified registered nurse anesthetist.[1]

The root of this controversy is a June 6, 2005, letter submitted by Governor Jim Doyle to the Administrator of the federal Centers for Medicare and Medicaid Services (CMS) requesting exemption (an opt-out) from the federal requirement for physician supervision of CRNAs. Governor Doyle's letter was sent pursuant to amendments made in 2001 to federal regulations relating to the Anesthesia Services Condition of Participation for Hospitals, the Surgical Services Condition of Participation for Critical Access Hospitals, and the Surgical Services Condition of Coverage for Ambulatory Surgical Centers. The 2001 amendments changed a longstanding CMS policy requiring physician supervision of the anesthesia care provided by CRNAs. The amendments permit hospitals and surgical centers to obtain exemptions from the CMS requirement for physician supervision of CRNAs if the state submits a letter to CMS signed by the Governor, requesting exemption from physician supervision of CRNAs.[3]

DECISION SUMMARY

Administration of anesthesia by a CRNA is part of the practice of medicine and surgery. Administration of anesthesia is also part of the practice of professional nursing by CRNAs, but not within the scope of professional nursing practice for nurses who are not CRNAs.

The law administered by the Medical Examining Board requires generally that a person be licensed as a physician to practice medicine and surgery. An exception in the law exists for persons lawfully practicing within the scope of a certificate granted to practice professional nursing by the Board of Nursing (BON).

A CRNA who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia is lawfully practicing within the scope of a certificate granted to practice professional nursing and comes within the exception. This exception does not require that a physician supervise the CRNA. Prior to November 1, 2000, the BON and its staff had interpreted the law to require that all CRNAs administer anesthesia under the supervision of a physician. However, a specific directive adopted by the Board of Nursing in administrative rules, effective November 1, 2000, requires that an APNP work in a collaborative relationship with a physician.

A CRNA who is not certified as an APNP and who administers anesthesia is not practicing within the scope of a certificate as an APNP. A CRNA who is not an APNP is not subject to the BON's requirements for APNPs, including the rule requiring collaboration with a physician. A CRNA who is not an APNP may administer anesthesia only under the supervision of a physician, a requirement unchanged by the BON rule effective in 2000.

This decision is supported by the substance and legislative history of 1993 Act 138, by BON rulemaking under Act 138, and by statutes that are related to the practice of a CRNA such as provisions governing liability insurance for health care providers in Wis. Stat. ch. 655 and administrative rules regulating hospitals in Wis. Adm. Code § HFS 124.

PROCEDURAL HISTORY

Petitioner, the Wisconsin Society of Anesthesiologists (WSA), filed a Petition for Declaratory Ruling on July 25, 2005, and an Amended Petition for Declaratory Ruling dated January 13, 2006, with proposed findings of fact and conclusions of law. Responsive materials including proposed findings and conclusions were filed by four interested parties: Wisconsin Board of Nursing (BON), Wisconsin Association of Nurse Anesthetists (WANA), Wisconsin Society of Podiatric Medicine (WSPM), and Wisconsin Podiatry Affiliated Credentialing Board (PACB). Petitioner supplemented its Amended Petition on April 17, 2006.

On June 30, 2006, Petitioner WSA filed a Motion For Summary Judgment with supporting documents. Briefs and other responsive materials were filed by interested parties, BON, WANA, WSPM and PACB. Reply materials were filed by the WSA on September 22, 2006. [4]

PETITION FOR DECLARATORY RULING

A declaratory ruling is an order in which an agency declares the rights, duties, status, or other legal relations between the parties and is similar to a declaratory judgment issued by a court. A court action for a declaratory judgment is the appropriate remedy to resolve a controversy where there may be doubt about legal rights and the plaintiff wishes to avoid the hazard of taking action in advance of a court determination. Declaratory judgments are intended to resolve uncertainties and controversies.[5]

The WSA's petition was filed under Wis. Stat. § 227.41 which, in part, states:

> Wis. Stat. § 227.41. Declaratory rulings. (1) Any agency may, on petition by any interested person, issue a declaratory ruling with respect to the applicability to any person, property or state of facts of any rule or statute enforced by it. . . .

The word "may" as used in Wis. Stat. § 227.41(1) grants the Board discretionary authority as to whether it will issue a declaratory ruling. Parties are not entitled to a declaratory ruling as a matter of right.[6]

Petitioner WSA contends that Governor Doyle erred when he requested an opt-out and that a declaratory ruling by the Medical Examining Board (MEB) is needed to eliminate reliance on the Governor's error. The WSA asserts that physicians who rely on the erroneous letter may be judged guilty of unprofessional conduct and further, may be liable for negligence if a patient is injured as a result of a physician's failure to supervise a CRNA. Also, according to the WSA, a CRNA who administers anesthesia without physician supervision may be denied malpractice insurance coverage.[7]

MOTION FOR SUMMARY JUDGMENT

The matter under present consideration before the Medical Examining Board is Petitioner WSA's June 30, 2006, Motion for Summary Judgment requesting that the MEB issue a ruling declaring that the administration of anesthesia by CRNAs must be performed under the supervision of a physician (or under the supervision of a podiatrist or dentist in cases where the Wisconsin Statutes permits such supervision).

The primary purpose of summary judgment procedure is to eliminate trial in cases in which a trial is unnecessary. A motion for summary judgment tests whether there are any disputed issues of fact.[8] Summary judgment also promotes the search for undisputed material facts.[9]

State agencies are authorized by Wis. Stat. § 227.42(1)(d) to develop summary disposition procedures, such as summary judgment, where the disposition does not require the resolution of any dispute of material fact.[10] Summary judgment procedures under Wis. Stat. § 802.08, applicable to civil actions before a court, are used here in responding to Petitioner WSA's motion. Under the methodology used by courts, the pleadings are examined to determine whether a claim for relief has been stated. If so, the inquiry shifts to whether any factual issues exist. Summary judgment must be entered ". . . if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."[11]

Petitioner's Amended Petition for Declaratory Ruling meets the requirements of a petition under Wis. Stat. § 227.41. Through proposed facts, responses and the submittal of affidavits and other materials, the parties have established the material facts relating to the administration of anesthesia. The remaining summary judgment issue is whether the moving party is entitled to a judgment as a matter of law.

BOARD RESPONSIBILITIES AND STRUCTURE

The practices of medicine and surgery and of professional nursing are regulated by the state under Wis. Stat. chs. 448 and 441, respectively, to protect public health, safety and welfare. Professional licensing boards are created to assure the competence of the licensed practitioner.[12] Like other statutes licensing the professions, chs. 441 and 448 were not enacted for the benefit of the persons licensed, but for the benefit and protection of the public.[13]

Within the organizational structure of Wisconsin state government, both the Medical Examining Board and the Board of Nursing are "examining boards."[14] By statute each examining board:

> Shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the

law relating to the particular trade or profession.[15]

Under Wis. Stat. § 227.10(1), "[e]ach agency shall promulgate as a rule each statement of general policy and each interpretation of a statute which it specifically adopts to govern its enforcement or administration of that statute."[16]

The MEB and BON are attached to the Department of Regulation and Licensing (DRL) and subject to statutory duties including the general obligation of each to "[i]ndependently exercise its powers, duties and functions prescribed by law with regard to rule-making, credentialing and regulation."[17] Each board's independent authority is subject to legislative oversight, including review of rulemaking under Wis. Stat. 227.19. Any dispute between an examining board and the DRL secretary is to be arbitrated by the governor.[18]

Interested party PACB is an "affiliated credentialing board" attached to the Medical Examining Board. [19] By statute, the PACB is to regulate with advice from the MEB. The PACB chairperson is to meet at least once every 6 months with the MEB to consider matters of joint interest.[20]

The term "*in pari materia*" refers to statutes relating to the same subject matter or having the same common purpose. Wis. Stat. chs 448 and 441 relate to the same subject matter and have the common goal of assuring the public that Wisconsin physicians and nurses are competent and protecting the welfare and safety of health care patients. As a rule of statutory interpretation, statutes *in pari materia* are read and construed together in harmony to achieve their common goal.[21]

FINDINGS OF FACT – ADMINISTRATION OF ANESTHESIA

Findings of Fact set forth below describe: the basic nature of anesthesia practice, (paragraphs 1 − 5), providers of anesthesia care and their qualifications (paragraphs 6 − 12), the anesthesia-related care typically provided to a patient before surgery (paragraph 14), the administration of anesthesia typically provided during a surgical procedure (paragraphs 16 − 23), and examples of emergency anesthesia complications (paragraphs 24 − 27). These findings were developed utilizing summary judgment procedures permitting a party to propose findings of fact and to contest proposed findings made by another party on the basis of admissible evidence.[22] A proposed factual finding may be included despite objections to the proposed finding if the proposed finding is material to the issues and no supporting affidavits or other factual evidence is submitted to support the objection.

LICENSE REQUIRED TO PRACTICE MEDICINE AND SURGERY

The "practice of medicine and surgery" is defined in Wis. Stat. § 448.01(9).[23] The definition is expansive and there is no doubt that the practice includes the administration of anesthesia. Wis. Stat. § 448.03(1)(a) requires a person to have a license as a physician to practice medicine and surgery:

> No person may practice medicine and surgery, or attempt to do so or make a representation as authorized to do so, without a license to practice medicine and surgery granted by the board.

There are exceptions to this physician licensing requirement in Wis. Stat. § 448.03(2), including the following:

> Nothing in this subchapter shall be construed either to prohibit, or to require, a license or certificate under this subchapter for any of the following:
>
> (a) Any person lawfully practicing within the scope of a license, permit, registration, certificate or certification granted to practice professional or practical nursing or nurse-midwifery under ch. 441, to practice chiropractic under ch. 446, to practice dentistry or dental hygiene under ch. 447, to practice optometry under ch. 449, to practice acupuncture under ch. 451 or under any other statutory provision, or as otherwise provided by statute.
> (b) . . .
> (e) Any person other than a physician assistant who is providing patient services as directed, supervised and inspected by a physician who has the power to direct, decide and oversee the implementation of the patient services rendered.

The exception in § 448.03(2)(a) for non-physicians lawfully practicing within the scope of another credential reflects the legal principle that the practice of the health care professionals may overlap.

Overlap in the scope of professional practice has been discussed in opinions of the Wisconsin Attorney General. [24]

The courts and this office have also recognized that the disciplines of various health care professionals may overlap. In *Kerkman, 142 Wis. 2d at 416,* the court recognized that "although chiropractors are permitted to use some medical tools when analyzing and treating a patient, this overlap does not transform the practice of chiropractic into the practice of medicine." In 68 *Op. Att'y Gen. 316 (1979),* my predecessor concluded that a physician could advise a patient whether continued chiropractic care was necessary without engaging in the unauthorized practice of chiropractic, even though that advice may technically fall within the definition of chiropractic practice. . . .

". . . In giving advice to patients, there is an overlap between what may properly be done by a chiropractor and a physician under their respective grants of statutory authority. In my view, a physician is given the latitude to perform services within his or her authority, whether those services overlap with professional services properly performed by a chiropractor, or other health care professional.

"To find otherwise would be to place unreasonable restraints on the practice of medicine. As summarized by the court in *Smith v. American Packing & Provision Co., 102 Utah 351, 130 P.2d 951, 955 (1942),* "the mere fact that a licensed profession extends in some degree into the field of some other licensed occupation, does not require the licensee to have a license in each of the fields into which his profession may overlap, unless the statutes impose such requirement." . . .[25]

The statute administered by the Medical Examining Board does not impose a requirement that a listed health care professional whose practice lawfully extends into the practice of medicine and surgery be licensed as a physician. Exceptions to the physician licensing requirement in Wis. Stat. § § 448.03(2)(a) acknowledges the possibility of overlap and provides a means of accommodating the situation by recognizing another license or requiring physician supervision.

ISSUE PRESENTED

The petition presents the issue of whether a CRNA who administers anesthesia without physician supervision is unlawfully practicing medicine and surgery.

If a CRNA who administers anesthesia is lawfully practicing within the scope of a certificate to practice professional nursing granted under ch. 441, the above Wis. Stat. § 448.03(2)(a) exception to the general rule applies and the CRNA is not required by Wis. Stat. § 448.03(1)(a) to have a license to practice medicine or surgery or be supervised by a physician. However if a CRNA is not lawfully practicing within the scope of a certificate granted under ch. 441, then the CRNA may administer anesthesia under the exception to the general rule in Wis. Stat. § 448.03(2)(e) that permits any person to provide patient services, but the services must be provided ". . . as directed, supervised and inspected by a physician who has the power to direct, decide and oversee the implementation of the patient services rendered."

As described below, a CRNA who is certified by the BON as an APNP (CRNA/APNP) and works in a collaborative relationship with a physician, and who administers anesthesia, is lawfully practicing within the scope of a certificate granted to practice professional nursing under ch. 441. This conclusion is supported by the statutory definition of professional nursing, the law authorizing certification of APNPs, rules adopted by the Board of Nursing to implement the APNP law, and laws related to CRNA practice such as the health care liability statutes and state rules regulating hospitals. CRNAs who are not APNPs do not meet the terms of this exception.

CREDENTIALING, SUPERVISION AND COLLABORATION REQUIREMENTS FOR CRNAS, APNS AND APNPS

The Board of Nursing regulates the practice of nursing under Wis. Stat. ch. 441. In 1993 Act 138 the legislature created Wis. Stat. § 441.16 requiring, inter alia, that the BON establish education, training or experience requirements that an RN must satisfy to be an advanced practice nurse (APN) and the additional requirements that an APN must satisfy to qualify for a certificate to issue prescription orders as an advanced practice nurse prescriber (APNP). These BON administrative rules are in Wis. Stat. ch. N 8. The term "advanced" as used in the phrase "advanced practice" in Wis. Stat. § 441.16 is not defined, but evidently refers to the requirement that APNs have education, training or experience in addition to that required for licensure as an RN.

The qualifications of an APN are described in Wis. Adm. Code § N 8.02(1), the BON rule defining an APN:

N 8.02 Definitions. As used in this chapter:
(1) "Advanced practice nurse'' means a registered nurse who possesses the following qualifications:
(a) The registered nurse has a current license to practice professional nursing in this state, or has a current license to practice professional nursing in another state which has adopted the nurse licensure compact;
(b) The registered nurse is currently certified by a national certifying body approved by the board as a nurse practitioner, certified nurse−midwife, certified registered nurse anesthetist or clinical nurse specialist; and,
(c) For applicants who receive national certification as a nurse practitioner, certified nurse−midwife, certified registered nurse anesthetist or clinical nurse specialist after July 1, 1998, the registered nurse holds a master's degree in nursing or a related health field granted by a college or university accredited by a regional accrediting agency approved by the board of education in the state in which the college or university is located.

The BON approves certifications by certain national certifying bodies in four areas of advanced practice nursing, including certification by the American Association of Nurse Anesthetists (AANA) as a CRNA.[26] Certification standards of the AANA require that an applicant for certification hold a license as an RN, complete an accredited nurse anesthesia education program and pass a national certification exam. Nurse anesthesia educational programs are from 24 to 36 months in length, depending on university requirements and are at the master's degree level or higher. The specific admission requirements to anesthesia educational programs and requirements for accreditation of programs are included in the materials submitted by interested parties.[27]

By definition a CRNA is an APN under Wis. Adm. Code § N 8.02(1). The BON does not separately certify and does not issue a unique certificate or other credential to a CRNA or an APN. The BON relies on the determination of the AANA that an RN meets CRNA certification standards. Only when a CRNA seeks an APNP certificate does the BON receive an application, review the applicant's credentials, issue a certificate, and identify the individual as an APNP on its website.[28]

Being an APN is a prerequisite for certification as an APNP. In addition to being and APN, under Wis. Adm. Code § N 8.03, an applicant to the BON for an APNP certificate must complete at least 45 contact hours in clinical pharmacology/therapeutics within 3 years preceding the application and pass a jurisprudence examination for advanced practice nurse prescribers. APNPs who are certified by the BON are required to complete an average of at least 8 contact hours per year in clinical pharmacology/therapeutics relevant to the APNP's area of practice. BON rules require APNPs who prescribe independently to maintain malpractice insurance. (Under Wis. Stat. ch. 655, all CRNAs are required to maintain liability insurance.)

If a CRNA obtains certification as an APNP, (becoming a CRNA/APNP) then Wis. Adm. Code § N 8.10(7), requires the CRNA/APNP to work in a collaborative relationship with a physician.

N 8.10(7) Advanced practice nurse prescribers shall work in a collaborative relationship with a physician. The collaborative relationship is a process in which an advanced practice nurse prescriber is working with a physician, in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise. The advanced practice nurse prescriber and the physician must document this relationship.

Collaboration is defined in Wis. Adm. Code § N 8.02(5):

N 8.02 Definitions. As used in this chapter: (1) . . .
(5) "Collaboration" means a process which involves 2 or more health care professionals working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer.

The BON has defined "direct supervision and "general supervision" in Wis. Adm. Code § N 6.02(6) and (7):

(6) "Direct supervision" means immediate availability to continually coordinate, direct and inspect at first hand the practice of another.

(7) "General supervision" means regularly to coordinate, direct and inspect the practice of another.

As defined, "supervision" and "collaboration" are distinct and dissimilar relationships. Under the BON's rule, a CRNA/APNP is required to work in collaborative relationship with a physician, not under the direct or general supervision of a physician.

Petitioner submitted extensive documentation showing that the BON staff or BON members have described the BON position on physician supervision of CRNAs to be that the administration of anesthesia is a delegated medical act that requires the supervision of a physician.[29] Putting aside the question of the legal consequence of these writings, none of which advanced to become administrative rules, and assuming the BON's position at the time the writings were made was that physician supervision of a CRNA was required, the record shows clearly that this particular policy or interpretation of law for APNPs was changed by an administrative rule. The BON's informal interpretations of CRNA supervision requirements expressed in the WSA Exhibits #5-#39 were replaced by Wis. Adm. Code § N 8.10(7), effective November 1, 2000, requiring APNPs to work in a collaborative relationship with a physician.[30]

1993 Wisconsin Act 138 (Act 138) requires the BON to grant a certificate to issue prescriptions to an advanced practice nurse who meets education, training and examination requirements established by the Board. The BON adopted Wis. Adm. Code ch. N 8 to implement 1993 Wisconsin Act 138, effective March 1, 1995.[31] The adopted Wis. Adm. Code § N 8.10 of 1995 is composed of only subsections (1) through (5). As do the current rules, the 1995 rules required in Wis. Adm. Code § N 8.10(5) that "[t]he board shall promote communication and collaboration among advanced practice nurses, physicians and other health care professionals, ..." The 1995 rules included the definition of collaboration currently in Wis. Adm. Code § N 8.02 (5). However, the 1995 rules in ch. N 8 did not require that APNPs work in a collaborative relationship with a physician.

The BON rule requiring a collaborative relationship resulted from a rulemaking order proposed as Clearinghouse Rule 99-126 (CR99-126). The rule draft published for hearing by the BON proposed creating a new rule, Wis. Adm. Code § N 8.06(1m), prohibiting APNPs from independently ordering laboratory testing except to assist the APNP in issuing a prescription. "Collaboration" was not mentioned in the rule draft.[32] The rule draft was referred to the Senate Committee on Health, Utilities, and Veterans & Military Affairs on February 10, 2000, for review under Wis. Stat. § 227.19.[33] The committee voted to recommend that the BON modify the rule by deleting proposed § N 8.06(1m) and creating new sections N 8.10(6) and (7). The BON adopted the modifications proposed by the committee. The effect of the modification was to permit APNPs to order laboratory tests for case management and to require APNPs to work in a documented collaborative relationship with a physician.

The appropriate agency process for changing a standard or a longstanding interpretation of a statute is through rulemaking.[34] The BON's longstanding interpretation of CRNA supervision requirements was changed by the BON rule in 2000. The fact that the collaboration requirement in Wis. Adm. Code § 8.10(7) resulted from a modification request made by a legislative committee conducting oversight review under Wis. Stat. § 227.19 is unique legislative history that gives weight to the correctness of the BON rule interpreting Wis. Stat. § 441.16.[35]

THE SCOPE OF PROFESSIONAL NURSING AND CRNA PRACTICE

Whether a CRNA/APNP who administers anesthesia is lawfully practicing within the scope of a credential granted under ch. 441 depends, in part, on the definition of "professional nursing." Under Wis. Stat. § 441.06(2), the holder of a license as an RN is ". . . authorized to practice professional nursing." "Professional nursing" is defined in Wis. Stat. § 441.001(4):

> "'Professional nursing' means the performance for compensation of any act in the observation or care of the ill, injured, or infirm, or for the maintenance of health or prevention of illness of others, that requires substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences. Professional nursing includes any of the following:
>
> (a) The observation and recording of symptoms and reaction.
>
> (b) The execution of procedures and techniques in the treatment of the sick under the general or special

supervision or direction of a physician, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state.

(c) The execution of general nursing procedures and techniques.

(d) Except as provided in s. 50.04 (2) (b), the supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants.

The definition of "professional nursing" in the introductory sentence of Wis. Stat. § 441.001(4) is expansive. The term "any act" is qualified only by acts that are either "in the observation or care of the ill, injured or infirm" or "for maintenance of health or prevention of illness" and require "substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences." As more fully discussed below, subsections (a) through (d) set out examples of professional nursing that are included within the general terms of the introductory sentence. These subsections do not describe the whole scope of practice for a professional nurse.

In Act 138 the legislature created Wis. Stat. § 441.16(3), mandating that the BON to,

. . . promulgate rules necessary to administer this section, including rules for all of the following:
(a) Establishing the education, training or experience requirements that a registered nurse must satisfy to be an advanced practice nurse. The rules promulgated under this paragraph shall require a registered nurse to have education, training or experience that is in addition to the education, training or experience required for licensure as a registered nurse.
(am) Establishing the appropriate education, training and examination requirements that an advanced practice nurse must satisfy to qualify for a certificate to issue prescription orders.
(b) Defining the scope of practice within which an advanced practice nurse may issue prescription orders.
(c) Specifying the classes of drugs, individual drugs or devices that may not be prescribed by an advanced practice nurse.
(cm) Specifying the conditions to be met for a registered nurse to do the following:
1. Administer a drug prescribed by an advanced practice nurse who is certified to issue prescription orders.
2. Administer a drug at the direction of an advanced practice nurse who is certified to issue prescription orders.
(d) . . . .

The BON's rules in response to the mandate are brief and broad. Rules adopted under the statute essentially require an APN to be an RN certified by a national certifying body as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist.[36] An APNP's scope of practice for issuing prescription orders is limited to ". . . the advanced practice nurse prescriber's areas of competence, as established by his or her education, training or experience."[37]

The scope of practice for an APN is carved out of the scope of practice defined in § 441.001(4)(intro) rather than from any of the subsections in the definition. This conclusion is evident from the fact that the key statutory characteristics of the APN are the requirement for ". . . education, training or experience that is in addition to the education, training or experience required for licensure as a registered nurse" and, for APNPs, eligibility to issue prescription orders. The examples of professional nursing in Wis. Stat. § 441.001(4)(a) - (d) do not reflect the advanced practice of an qualified APN holding national certification as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist. The conclusion that the CRNA scope of practice is not within the four subsections of Wis. Stat. § 441.001(4) is evident from the description of anesthesia administration in the Findings of Fact paragraphs 15. – 23., below. The tasks are complex, requiring knowledge, skills and abilities consistent with the additional education, training and experience and national certification required to a CRNA.[38]

Petitioner maintains that CRNAs who are certified as APNPs may independently prescribe anesthetic drugs without supervision, but may not administer anesthesia without physician supervision.[39] Petitioner's conclusion is contrary to Wis. Stat. § 441.16(3)(cm)2. which requires the BON to specify the conditions to be met for an RN to "[a]

dminister a drug at the direction of an advanced practice nurse who is certified to issue prescription orders." The statute does not separate the authority to prescribe from the authority to treat and care for a patient.[40] To the contrary, the statute states that APNP practice includes directing an RN to administer drugs prescribed by the APNP.

Petitioner WSA references a note in the drafting records of the Wisconsin Legislative Reference Bureau relating to 1993 Assembly Bill 756, which was enacted as Act 138. In that note, the drafter expresses an opinion that bill redraft #LRBs0300/3dn,

> ". . . creates a category of RNs called 'advanced practice nurses'. The only thing that an advanced practice nurse may do that any other registered nurse may not do is qualify for a certificate to issue prescription orders. . . ."[41]

The WSA references this drafter's note to support its position that Act 138 simply expanded the prescriptive authority for APNPs and did not affect the scope of professional nursing so as to permit APNPs to administer of anesthesia except as a delegated medical act under physician supervision.[42] The drafting file in the Legislative Reference Bureau (LRB) for 1993 Assembly Bill 756 also includes a memorandum to the chairperson of the Health Committee from the Government Relations Director of the State Medical Society making four recommendations for modifications to the bill.[43] The memorandum describes the nature of the change anticipated from AB 756 to be "a new level of practice," involving "expanded responsibility" and urges that legislative direction is needed to ensure that ". . . [o]nly the most qualified nurses are able to undertake this dramatically increased responsibility." Legislative Reference Bureau drafting file records indicates that recommendations in the State Medical Society memorandum were generally incorporated into LRB draft number LRBs0300/5 introduced as Assembly Substitute Amendment 1 to 1993 Assembly Bill 756 and enacted as Act 138.

While Act 138 did not amend the definition of "professional nursing" for APNs, the legislative history of Act 138 and the terms of Wis. Stat. § 441.16, as created by the act, confirm that an APN has a level of responsibility and practice as well as education, training and experience beyond that required of a registered nurse (RN). Statutes are not to be interpreted so as to render the statute a nullity as would an interpretation of Wis. Stat. § 441.16 that requires additional education, training and experience for APNs, but declines to recognize that APNs have an expanded responsibility as a result of meeting the requirements. A plain-language reading that harmonizes Wis. Stat. §§ 441.001 (4) and 441.16 and avoids unreasonable and absurd results permits an APN to engage in areas of professional nursing practice consistent with the APNs advanced education, training and experience that are not available to an RN. An amendment to the definition of "professional nursing" was unnecessary to accomplish this result. In determining the scope of practice of an "advanced practice nurse" the term "advanced" has to be given its ordinary meaning and effect."[44]

The broad statutory scope of professional nursing practice is delimited by administrative rule and by the education, training and experience of each credential holder. An RN may not perform services for which the RN is not qualified by education, training or experience.[45] Wis. Adm. Code § N 8.10(7) requires that an APNP work in a collaborative relationship with a physician. ". . . to deliver health care services within the scope of the practitioner's professional expertise. . . ." (emphasis added). The scope of advanced practice nursing is circumscribed in Wis. Adm. Code § N 8.02(1)(b) by reference to national bodies that certify registered nurses to practice as advanced practice nurses. In Wis. Adm. Code § N 8.06(1) the rules also limit the scope of an APNP's practice by the restriction that an APNP "may issue only those prescription orders appropriate to the advanced practice nurse prescriber's areas of competence, as established by his or her education, training or experience."

The parties dispute whether Wis. Stat. § 441.001(4)(a) through (d) limit the scope of the general definition of "professional nursing" in the first sentence of the definition. If there is textual evidence that the legislature intended a narrow meaning of "includes" to apply, courts have read the word "includes" as a term of limitation or enumeration using the doctrine of *expressio unius est exclusio alterius* (the expression of one thing excludes another.) In statutory definitions, "means" is a term indicating limitation or completeness, whereas "includes" is a term indicating partiality and expansiveness.[46] "'Means' is complete and 'includes' is partial."[47] The word "includes" appears in the sentence immediately following the general definition of "professional nursing," in which the word "means" is utilized. Had the legislature intended the subsections of the second sentence of § 441.001(4) to be terms of limitation or exclusivity, it would have used the word "means," as it did in the first sentence. As enacted, the second sentence is a list of examples of professional nursing. Recent legislative modifications to the statutory definition of "professional nursing" in 2001

Wisconsin Act 107 support the conclusion that subsections 441.001(4)(a) through (d) are "examples" of professional nursing.[48]

Petitioner WSA references an opinion of the California Attorney General on whether a California CRNA may administer regional anesthetics under a standardized procedure. The California Attorney General concluded that,

> . . . a registered nurse and thus a Certified Registered Nurse Anesthetist may lawfully administer a regional anesthetic when ordered by and within the scope of licensure of a physician, dentist, or podiatrist or clinical psychologist but not pursuant to a "standardized procedure" as defined in section 2725.[49]

The WSA urges that the reasoning of the California opinion be used in interpreting the Wisconsin definition of "professional nursing." The California opinion is not appropriate precedent for interpretation of the Wisconsin definition of "professional nursing" because of the specific question considered and the unique history of California law.

Wisconsin law requires CRNAs who are certified as APNPs to work in a documented collaborative relationship with a physician. Unlike the question presented to the California Attorney General, the legal questions presented by the WSA petition do not involve whether a CRNA may practice under "standardized procedures" established in collaboration with heath care facilities and providers. Every administration of anesthesia is unique.[50] A collaborative relationship with a physician is more likely to take into account the particular needs of a patient than a standardized procedure.

Section 2725 of the California Nursing Practice Act, the statutory definition of "professional nursing" interpreted in the California opinion, is structured similarly to Wis. Stat. § 441.001(4) in that an introductory paragraph states a general definition, then adds the words "and includes all of the following:" followed by four subsections identifying more specific examples.[51] The California Attorney General points out that section 2726 of the Nursing Practice Act, enacted as part of the same statute which enacted the basic definition of "professional nursing," declares that "this chapter [the Nursing Practice Act] confers no authority to practice medicine or surgery" . . . "[e]xcept as otherwise provided herein." The California opinion also notes that, "[t]he use of nurses to administer anesthetics has had a turbulent history in California law."[52] The turbulent history is summarized in the Attorney General's opinion. Based on the interplay between sections 2725 and 2726 and parts of the "turbulent history" the opinion finds ambiguity in California's definition of professional nursing. A foundation of the California opinion is the application of the doctrine of *ejusdem generis,* a principle of statutory interpretation described by Petitioner WSA as "when general words follow specific words in describing a subject, the general word will be interpreted to include only items of the same type as the specifics listed."[53]

The *ejusdem generis* principle is not applicable to Wis. Stat. § 441.001(4). The Wisconsin Statute defining "professional nursing" does not have a turbulent history and Wis. Stat. ch. 441 does not include a restriction similar to section 2726 of the California Nursing Practice Act. As indicated in the WSA description, the *ejusdem* principle is usually applied to a series of specific words followed by a general word. The definition of "professional nursing" is not such a series. The definition has two parts: "professional nursing means" followed by a general descriptor; then "professional nursing includes" followed by more specific descriptors. Restricting the expansive definition of "professional nursing" to only acts of the same type as those described in subsections (a) through (d) of Wis. Stat. § 441.001(4) directly contradicts the expressed legislative policy in 1993 Wisconsin Act 138, confirmed in the legislative review of the rules in Wis. Adm. Code ch N 8, to provide for an area of advanced practice nursing requiring ". . . education, training or experience that is in addition to the education, training or experience required for licensure as a registered nurse."[54]

RELATED LAWS

The fact that that professional nursing includes the administration of anesthesia is evident in laws related to CRNA practice. In 1975 the legislature, perceiving a crisis in health care liability coverage, enacted Chapter 37, Laws of 1975, creating ch. 655 of the Statutes.[55] Among other things, ch. 655 requires physicians, nurse anesthetists and hospitals to participate in a plan of healthcare liability coverage under rules of the Commissioner of Insurance. The plan was, when enacted, and still is, mandatory for state "health care providers" now defined by Wis. Stat. § 655.001(8):

> "Health care provider" means a medical or osteopathic physician licensed under ch. 448, a nurse

> anesthetist licensed under ch. 441 or a hospital as defined by s. 140.24 (1) (a) and (c), but excluding those facilities exempted by s. 140.29 (3).

In Wisconsin, under Wis. Stat. ch. 655, nurse anesthetists are classified the same as physicians and differently from other health care professionals. [56] Although changes have been made to Wis. Stat. ch. 655 since 1975, the chapter still provides the exclusive procedure for malpractice claims brought against "health care providers" *i.e.* physicians, nurse anesthetists, hospitals and their related organizations.[57] (Under present Wis. Stat. § 655.005, malpractice claims against employees of health care providers are also subject to ch. 655.[58])

The fact that CRNAs have a unique scope of practice and that CRNAs are significant providers of anesthesia services in Wisconsin is evident in Wis. Stat. ch. 655, which has provided for a healthcare liability plan that is mandatory for physicians and CRNAs since 1975.

The Wisconsin Department of Health and Family Services (DHFS) administers rules in Wis. Adm. Code ch. 124 governing standards for the operation of hospitals under the "Hospital Regulation and Approval Act."[59] The rules are intended to promote safe and adequate care and treatment of patients in hospitals. Among other things the rules require that hospitals have policies and procedures relating to the staffing and functions of different services provided by hospitals. The hospital rules regulating surgery and anesthesia services identify nurse anesthetists as alternative healthcare providers to physicians and anesthesiologists. The surgery policies rule, for example, requires that,

> 4. There shall be adequate provisions for immediate postoperative care. A patient may be directly discharged from post-anesthetic recovery status only by an anesthesiologist, another qualified physician or a registered nurse anesthetist.[60]

The DHFS rule for anesthesia use requirements in hospitals includes the following:

> 3. If anesthetics are not administered by a qualified anesthesiologist, they shall be administered by a physician anesthetist, dental anesthetist, podiatrist or a registered nurse anesthetist, under supervision as defined by medical staff policy. The hospital, on recommendation of the medical staff, shall designate persons qualified to administer anesthetics and shall determine what each person is qualified to do.
> 4. The services provided by podiatrist, dentist or nurse anesthetists shall be documented, as well as the supervision that each receives.
> 5. If a general anesthetic is used and a physician is not a member of the operating team, a physician shall be immediately available in the hospital or an adjacent clinic to assist in emergency situations.[61]

These rules not only support the conclusion that CRNAs are involved in administration of anesthesia in hospitals, but are structured to permit a CRNA/APNP to practice without physician supervision. Under sub. 5. of these rules, a CRNA may administer anesthesia even if a physician is not a member of the operating team if the medical staff designates the CRNA as qualified. The record includes an affidavit of Irene Temple, an attorney employed by the DHFS, who has responsibility to advise the Department's Bureau of Quality Assurance regarding the interpretation of the Department's rules relating to the regulation of hospitals. With respect to supervision, Irene Temple's affidavit includes the statement that,

> Section HFS 124(3) does not specify the extent of supervision of anesthetists who are not anesthesiologists. Under the rule, the extent of supervision required, if any, is to be determined by the hospital through its medical staff policies.

These rules identify a CRNA as a provider of anesthesia service in a hospital and authorize assignment of substantial responsibility to the CRNA.

LIMITATIONS ON PODIATRISTS

> Under Wis. Stat. § 448.60(4) "Podiatry" or "podiatric medicine and surgery" is defined to mean,
>
> . . . that branch or system of the practice of medicine and surgery that involves treating the sick which is limited to conditions affecting the foot and ankle, but does not include the use of a general anesthetic unless administered by or under the direction of a person licensed to practice medicine and surgery under subch. II.

Through an affidavit of its chairperson, Dr. Lisa Reinicke, the PACB stated its position that CRNAs routinely administer general anesthesia to podiatric surgical patients without the supervision of a physician, especially in rural hospitals.

According to Dr. Reinicke, requiring CRNAs to be supervised by a physician would likely impinge upon patient access to podiatric surgical care.

As described above, a CRNA/APNP within an exception to the physician licensing statute. The statute regulating podiatrists contains a similar exception. Under Wis. Stat. § 448.62(1) the statute requiring a podiatry license does not apply to "[a] person lawfully practicing within the scope of a license, permit, registration or certification granted by this state or the federal government." Consequently, the statutory definition of podiatry does not restrict the lawful practice of a CRNA/APNP.

Rules of the BON mandate that a CRNA/APNP work in a collaborative relationship with a physician. Apart from the required collaborative relationship, a CRNA/APNP practices independently, not under delegated authority from a physician or podiatrist. Of course, both the podiatrist and the CRNA/APNP are required to comply with the appropriate rules of the DHFS governing surgical and anesthesia services which may require that a physician by present or immediately available. For CRNAs not APNP certified, compliance with Wis. Stat. § 448.03(1) requires that the administration of anesthesia by the CRNA be directed, supervised and inspected by a physician who has the power to direct, decide and oversee the patient services. Use of CRNAs to administer general anesthesia appears to be a matter of joint interest between the MEB and the PACB that may warrant discussion under the procedure in Wis. Stat. § 15.085(3)(b)[62].

CONCLUSION

While material facts relating to the administration of anesthesia are generally agreed to by the parties, Petitioner WSA has not shown that it is entitled to judgment on its motion as a matter of law. The conclusions of law proposed by the petitioner relating to physician supervision when a CRNA administers anesthesia are not fully consistent with established state law. There is an overlap in the health care practice of physicians and CRNAs. The law that requires a license as a physician to practice medicine and surgery exempts persons lawfully practicing within the scope of a certificate to practice professional nursing issued by the BON. Administration of anesthesia is included within the statutory definition of "professional nursing." A CRNA may lawfully administer anesthesia without physician supervision under the exemption if certified as an APNP and if the CRNA maintains and documents a collaborative relationship with a physician.

A CRNA who is not certified as an APNP is not subject to the BON rule requiring a collaborative relationship with a physician and does not qualify for the same exemption from the physician licensing requirement as a CRNA/APNP. Longstanding policies and administrative rules of the BON require physician supervision of administration of anesthesia by a CRNA who is not certified as an APNP.

The appropriate order is to deny petitioners motion for summary judgment.

The proposed order also dismisses the Petition for a Declaratory Ruling because the Medical Board's decision on Petitioner's summary judgment motion resolves the controversies presented by the petition. The issues raised by the Petition are essentially questions of law. Additional facts developed from a contested hearing would not change the legal analysis of the central issues. None of the parties has a right to a declaratory ruling. There is no necessity for a declaratory ruling to permit physicians and CRNAs to avoid unprofessional conduct or malpractice findings as was contended by the WSA. Hospitals and insurers may rely on Wis. Stat. chs. 441 and 448 and BON rules to accept the legitimacy of anesthesia administration by CRNA/APNPs working in a collaborative relationship with a physician.

Citing Act 138 and *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983), the BON and the WANA argue that the practice of professional nursing has evolved because of changes in healthcare technology, delivery systems, education and training. They contend that the delivery of health care is now provided by a team of professionals who work interdependently in collaborative relationships rather than traditional hierarchical or supervisory models. Although there is a background of change in Wisconsin law relating to the scope of professional nursing consistent with a *Sermchief* type of analysis, the petition in this case presents an issue that is determined directly by reference to statute and administrative rule.

The Medical Examining Board or the Board of Nursing may determine that the petition has raised public policy issues that need further attention. If so, administrative rulemaking seems preferable to the declaratory ruling process for these quasi-legislative tasks because rulemaking affords opportunity for a hearing to receive public comments and

results in a published rule.[63]

The conclusion in this decision that a CRNA who is certified as an APNP is required to work in collaboration with a physician, rather than under physician supervision, meets public policy criteria of occupational regulation. A CRNA/APNP may not perform services for which he or she is not qualified by education, training or experience. The state assures the public of the competence of the CRNA/APNP by a regulatory system that includes defined education and training requirements, an examination, experience and credentialing as an RN, professional practice standards, mandated liability insurance coverage, regulation by a related state agency, and mandated collaboration with a physician.

FINDINGS OF FACT

The Findings of Fact, below, are based on the proposals and responses of the petitioner and interested parties that are in the record. [64]

BASIC NATURE OF ANESTHESIA PRACTICE

1. Anesthesiology is a healthcare specialty concerned with the pharmacological, physiological and clinical basis of anesthesia and related fields, including resuscitation, intensive care, respiratory care, and acute and chronic pain. The practice of anesthesiology is dedicated primarily to the relief of pain and total care of the patient before, during and after surgical and obstetrical procedures.

2. The practice of anesthesiology includes:

a. The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures. This includes pre-operative, intra-operative and post-operative evaluation and treatment of these patients;

b. The protection of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver) under the anesthesia and the stress of surgical and other medical procedures;

c. The management of airway access (both routine and difficult);

d. The management of problems regarding pain relief;

e. The management of cardiopulmonary resuscitation;

f. The management of routine and potential problems in pulmonary care; and,

g. The management of critically ill patients in special care units.

3. The practice of anesthesia requires the exercise of judgment concerning:

a. Selection of the appropriate drugs for anesthesia and for treatment of a patient's other medical conditions while under anesthesia;[65]

b. Determination that the patient is fit to undergo anesthesia;

c. Administration of the anesthetic, resuscitative, and related drugs during the course of the procedure and adjusting the mixture of drugs, oxygen, and other gases to keep the patient alive while anesthetized;

d. Monitoring the patient throughout the procedure; and,

e. Intervening in emergencies, such as a heart attack or an asthma attack, that a patient may suffer while under anesthesia.

4. There are different kinds of anesthesia. "General anesthesia" is the administration of drugs which causes loss of consciousness as the result of which the patient is unable to make meaningful responses. "Moderate" is the administration of a drug to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or a deaf person. "Regional anesthesia" is the administration of anesthetic agents to a patient to interrupt pain nerve impulses without loss of consciousness. It includes epidural, caudal, spinal, brachial plexus, and peripheral nerve anesthesia.

5. Notwithstanding great reductions in mortality rates from anesthesia over the past several years, the administration of anesthesia is an inherently risky process with significant potential for morbidity or mortality.

PROVIDERS OF ANESTHESIA CARE

6. Providers of anesthesia care may be divided into two basic groups: physicians specially trained in anesthesiology, and non-physician providers. The first group includes anesthesiologists, anesthesiology residents (a physician who is presently in an approved anesthesiology residency program), and other physicians with particularized training in the specialty. The second group includes CRNAs and Anesthesiology Assistants (AAs). An anesthesiologist working with either an anesthesiology resident, a CRNA, or an AA is referred to as the "Anesthesia Care Team." Others who have patient care functions during the perioperative period include post-anesthesia nurses, critical care nurses, respiratory therapists, and support personnel (anesthesia technologists and technicians, anesthesia aides, blood gas technicians, respiratory technicians, and monitoring technicians).

7. An anesthesiologist is a physician who specializes in the practice of anesthesia. Anesthesiologists function as "perioperative" physicians, meaning that the anesthesiologist is usually the single medical doctor responsible for providing comprehensive care to a patient at all stages of a surgical procedure. This includes medically evaluating the patient before the procedure, consulting with the surgical team, providing pain control, amnesia, and life support during the procedure, supervising post-operative care, and determining when a patient may safely be discharged.

EDUCATION AND TRAINING OF ANESTHESIOLOGISTS

8. Anesthesiologists must complete twelve years of formal education:

a. Four years of science - intensive pre undergraduate education;

b. Four years of medical school in which the individual gains knowledge of the fundamental science of the human condition (biochemistry, biophysics, anatomy, pharmacology, physiology, and pathophysiology of disease states) and receives extensive clinical instruction and experience in medical diagnosis and therapy; and,

c. Four years of residency training that includes one year of clinical medicine and three years of clinical anesthesiology.

d. Anesthesiologists receive extended training in pharmacokinetics, which is the quantitative study of the action of drugs in the body over a period of time including absorption, distribution, localization, biotransformation, and excretion. Knowledge of these processes is used to match the appropriate medications to a particular patient. Many anesthesiologists also elect to receive training in subspecialties such as pediatric anesthesia, critical care medicine, cardiac anesthesia, and pain management.

9. Anesthesiologists by virtue of their education and training are qualified to make medical judgments with regard to all aspects of the administration of anesthesia including, without limitation, emergency intervention and rescue from complications.

EDUCATION AND TRAINING OF CRNAS

10. CRNAs are registered nurses who have attended an accredited nurse anesthesia education program and, upon graduation therefrom, passed a national certification exam and thereby obtained national certification as a CRNA.

a. A certified registered nurse anesthetist must graduate from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessors, and pass the certification examination administered by the Council on Certification of Nurse Anesthetists or its predecessors.

b. There are more than 80 nurse anesthesia educational programs in the United States, all affiliated with, or operated by universities. Approximately one-half of those programs are located in schools of nursing or schools of health sciences or other appropriate graduate schools.

c. The programs offered for nurse anesthesia education range from 24 to 36 months in length, depending on university requirements and all are at the master's degree level or higher.

d. Accredited nurse anesthesia education programs provide graduate level science courses along with clinical anesthesia to prepare the student to become competent nurse anesthesia providers. The science curriculum of graduate nurse anesthesia programs includes the following:

i) A minimum of 135 hours in Advanced Anatomy, Physiology and Pathophysiology.

ii) A minimum of 90 hours in Advanced Pharmacology.

iii) A minimum of 45 hours of Chemistry and Physics related to anesthesia.

iv) The minimum requirement of 90 hours of courses in anesthesia practice provides content such as induction, maintenance, and emergence of anesthesia, airway management, anesthesia pharmacology; and anesthesia for special patient populations such as obstetrics, geriatrics and pediatrics.

v) Many accredited nurse anesthesia education programs provide scientific inquiry and statistics as well as active participation in student and faculty-sponsored research and clinical residencies

which allow students to learn anesthesia techniques, test theory and apply knowledge to clinical problems.

vi) Nurse anesthesia educational programs provide an average of 1,595 hours of clinical experience for each student.

11. The general requirements for admission into a nurse anesthesia education program are:

a. A degree in nursing;

b. A license as a registered nurse; and,

c. A minimum of one year of acute care nursing experience.

12. In most instances, in Wisconsin, anesthesia care is typically furnished by an anesthesiologist or administered by a CRNA, AA, or anesthesiology resident, in each case acting under the direction of an anesthesiologist. The following paragraphs describe typical anesthesia care where the anesthesia care is performed by the anesthesiologist alone or by a CRNA, AA, or anesthesiology resident that is being directed by the anesthesiologist.

a. CRNAs who have successfully completed an accredited nurse anesthesia program have the education and training necessary to successfully and independently administer anesthesia.[66]

b. Under Wisconsin law, a CRNA who is certified as an APNP may administer anesthesia without the supervision of a physician, but must work in a collaborative relationship with a physician.

c. Under Wisconsin law, a CRNA who is not certified as APNP may administer anesthesia only as directed, supervised and inspected by a physician.

13. The specific tasks involved in anesthesia care, which are described in the following paragraphs, are generally performed by: (1) an anesthesiologist; or (2) a CRNA, AA, or anesthesiology resident[67]. The particular tasks that the anesthesiologist reserves for himself/herself to perform are variable by the institution, by the normal practice of each anesthesiologist in that institution, and by the particular circumstances in each instance of anesthesia care. The particular tasks assigned to each CRNA, AA, or anesthesiology resident are also variable by the institution, by the normal practice of each anesthesiologist in that institution, and by the particular circumstances in each instance of anesthesia care.

14. Typically, a patient goes to a primary care physician for a routine check up or with a medical complaint. If the physician sees the potential need for a surgical procedure, the physician refers the patient to a surgeon. The surgeon then reviews the patient record, examines the patient and determines the following: (1) if a surgical procedure is indeed needed; (2) the type of surgical procedure needed; and, (3) the benefits and risks of the procedure based on the procedure and the patient s health. The surgeon then provides the patient with information on the procedure and the benefits and risks of the procedure. If a procedure is deemed necessary and the patient consents to the procedure, the patient is then scheduled for the procedure by the surgeon or his/her office personnel.

15. A patient who will receive anesthesia in connection with such procedure typically receives the following pre-operative care:

a. At some point following the initial appointment with the surgeon, and prior to the procedure, the patient receives an anesthetic preoperative assessment work-up. This consists of a careful and concise review of the patient‘s medical record and pertinent labs and tests. Included in the review are details on patient current history of medical illness or injury, past medical history, past surgical and anesthetic history (including complications or adverse reactions that occurred), review of patient‘s blood relative anesthetic complications, review of organ systems and organ pathology with the potential influence on the management of anesthesia (neurological, cardiovascular, pulmonary, gastrointestinal, renal, hepatic, musculocutaneous, endocrine, gynecological, urological, and hematological), review of current vital signs (blood pressure, heart rate, temperature, respirations), review of allergic reactions (medication, latex, food) and current drug regimen, notation of the time of last food or fluid consumption as part of the analysis of risk of aspiration, and review of laboratory data and radiological studies that could influence the management of anesthesia. When conducting such a review, it is extremely important to be able to recognize certain symptoms of illness or infirmity (sometimes subtle), which may have serious consequences or lead to complications when the patient is exposed to an anesthetic. Examples of instances in which recognition of subtle symptoms are necessary include patients who may have undiagnosed sleep apnea and patients who may have undiagnosed cardiac ischemia. If such symptoms are not recognized and diagnosed prior to the procedure, the administration of anesthesia could have serious consequences. In the case of an undiagnosed sleep apnea, there could be issues with airway placement, ventilation in the operating room, and post-operative ventilation.

a.1. This anesthetic preoperative review may be performed by the anesthesiologist assigned to the procedure (if known ahead of time), or it may be done prior to the time that the anesthesia assignments are made. When the anesthetic preoperative review is done prior to the time that anesthesia personnel assignments

are made for a procedure, it may be performed by: (1) another anesthesiologist; (2) a CRNA; (3) an AA; (4) an anesthesiology resident; or (5) a nurse working in the anesthesia preoperative work clinic or surgical clinic, or assigned to perform daily anesthetic preoperative work-ups. Typically, there is a department standardized preoperative sheet, which contains lists of desired information and tests to be collected from the patient record, that is filled out. Once assignments are made, the preoperative anesthesia work is always thoroughly reviewed by the anesthesiologist when an anesthesiologist is in charge of the anesthetic.[68]

a.2. Next a physical exam of the patient is performed, focusing on cardiac and pulmonary systems, organ systems which the surgery involves, organ systems that the patient expresses concern about, and organ systems of concern following patient chart review and history. The patient airway is then examined for signs of potential difficulty with airway management or intubation (placement of a breathing tube). This physical exam and airway exam are usually performed by both the staff anesthesiologist responsible for the anesthetic plan, delivery, and postoperative care of the patient, and by the non-physician provider (CRNA, AA) or anesthesiology resident, if also assigned to deliver the anesthetic.

b. Following review of history, review of surgical procedure, and physical exam, an anesthetic management plan is developed consisting of the decision on type of anesthetic to be delivered (general, regional: spinal or epidural, peripheral nerve block, monitored anesthesia care), plan for airway management, determination of invasive vascular catheters to be placed (peripheral I.V., arterial line, central venous line), and determination of monitors needed including standard monitors (electrocardiogram, non-invasive blood pressure, pulse oximetry, capnography, temperature) and invasive monitors (arterial blood pressure, central venous pressure, and pulmonary artery catheter allowing for the measurement of right atrial, right ventricular, left atrial, and cardiac output measurements). Consideration of other monitors/tests needed for the surgical procedure (EEG, somatosensory evoked potentials) is given, as these may also influence choice of anesthetic.

c. The anesthesiologist and other Anesthesia Care Team members (CRNA, AA, or anesthesiology resident) talk to the patient and give the patient the information regarding: (1) the anesthetic plan to be delivered; (2) the monitoring of the patient that will occur during the procedure, including any invasive lines that will be placed for monitoring purposes; and (3) the benefits and risks of the particular type of anesthesia and monitors and invasive lines that will be used.[69]

d. The anesthesiologist or other involved physician signs orders for any pre-operative drugs that will be given to the patient prior to the procedure. A CRNA with prescriptive authority may also prescribe pre-operative drugs pursuant to the CRNA's own DEA number and prescriptive authority.

e. Following approval, the anesthetic plan is then carried out by the anesthesiologist if working alone, or by the CRNA, AA, or anesthesiology resident.[70]

16. The dispensing of anesthesia is usually preformed by an anesthesiologist, CRNA, AA, or anesthesiology resident. The anesthesiologist, CRNA, AA, or anesthesiology resident go to the pharmacy and check out the narcotics that were prescribed pursuant to the anesthesia plan. The anesthesiologist, CRNA, AA, or anesthesiology resident will then place the medications in the operating room. In addition, there is typically a cart in the operating room that has the non-narcotic standard medications available.

17. Shortly before the administration of anesthesia, the anesthesiologist, CRNA, AA, or anesthesiology resident inspects and sets-up the anesthesia machine. The anesthesia machine includes a source of compressed gases, a breathing system, a ventilator, anesthetic vaporizers, and flowmeters to deliver known flows and concentrations of anesthetic gases into the breathing system. Suction, monitors, drugs, and airway equipment are also set-up in the operating room.

18. As with the other tasks involved in anesthesia care, the tasks involved in the actual administration of anesthesia are performed by (1) the anesthesiologist; or (2) a CRNA, AA, or anesthesiology resident.[71] When the CRNA, AA, or anesthesiology resident acts under the direction of the anesthesiologist, an anesthesiologist is either in the room of the procedure or is available to reach the room of the procedure within minutes of being paged to the room. Depending on the type of anesthesia involved, the administration of anesthesia typically proceeds as follows:

a. General anesthesia.

i. A peripheral I.V. catheter is usually put in place (with the exception of the pediatric patient who may be put to sleep via mask induction), and in many instances, a sedative, anxiolytic (anxiety reducing medication), and/or amnestic (medicine decreasing ability to remember) is given to the patient. The patient is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, when needed to monitor the patient for anesthetic induction (delivery of the anesthetic to achieve an unconscious state) invasive monitors are also placed (i.e. arterial line or central venous line).

ii. The patient's vital signs are continuously monitored and recorded on the anesthetic record every five minutes, or more frequently as needed. Blood pressure and heart rate are usually maintained at the patient's normal baseline value, however, for some cases it is preferred that the patient's blood pressure be maintained

slightly hypertensive (above normal) to maintain cerebral (brain) perfusion pressure, or slightly hypotensive (below normal) to decrease the amount of bleeding. Intravenous fluid is delivered at a rate determined by the patient's hourly normal requirement, and the amount needed for replacement of blood and body fluid lost during the procedure. Loss of blood, plasma, and coagulation factors are monitored during the procedure, and products are replaced as needed. Patient temperature is maintained at a normal level.

iii. The patient is pre-oxygenated with a mask and breathing system containing 100% oxygen for approximately 5-6 minutes. If the patient is not at risk for aspiration or potential difficult airway, I.V. induction of anesthesia occurs with the delivery of a hypnotic drug. This produces a rapid onset of unconsciousness. Once it is determined that the patient can be ventilated by mask, an intravenous paralytic drug is given. This causes muscle paralysis that facilitates direct laryngoscopy for intubation of the trachea (placement of a breathing tube in the trachea). A breathing tube is then placed into the patient's trachea. The placement of the breathing tube in the patient's trachea is then confirmed by the presence of end tidal carbon dioxide (capnography showing the patient exhalation of carbon dioxide), and patient breath sounds on auscultation (listening) of the lungs.

iv. If the patient is at risk for aspiration, a "rapid sequence induction" is performed. In a rapid sequence induction, the patient is given a hypnotic that is immediately followed by a dose of a very rapid acting paralytic drug. Cricoid pressure (pressure held over the cricoid cartilage on the neck which occludes the esophagus) is maintained on the patient's neck and esophagus until the breathing tube is inserted, and placement in the trachea is confirmed.

v. If the patient presents a potentially difficult airway (i.e. it is unlikely that a breathing tube can be placed by routine direct laryngoscopy), a fiberoptic scope may be used for placement of the breathing tube. If its use is anticipated, this equipment is set up in advance of patient induction of anesthesia. Following placement of the airway breathing tube, the patient is usually placed on the ventilator, which is set to deliver an adequate volume of breathing gases and oxygen at a specific rate. The patient is maintained in a pain-free asleep state with the continued delivery of anesthetic and narcotics. Muscle paralysis is maintained and monitored as needed for the surgical procedure. Antibiotics are administered to prevent infection prior to the beginning of the procedure, and re-dosed as needed.

vi. Following the end of procedure, in most instances, the patient is allowed to awaken. Delivery of the anesthetic is discontinued, and the patient is extubated (breathing tube removed) when it is determined that he or she is sufficiently awake with adequate airway reflexes to prevent aspiration. The patient is then transported either to the post-anesthesia care unit (PACU) or the intensive care unit (ICU). The patient is placed on appropriate monitors and vital signs are taken. Report of the patient's pre-operative history, and intraoperative history and management is given to the attending nurse. Post-operative orders for blood pressure management, pain management, fluid management, and postoperative nausea management are written.

b. Moderate sedation (monitored anesthesia care - "MAC").

i. The administration of moderate sedation (MAC) includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of moderate sedation (MAC) includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. The patient is sedated with medications (usually a mix of anxiolytic, amnestic agents, hypnotic agents and narcotics). Care is exercised to not over sedate the patient to the point that supplemental respiration needs to be initiated. Supplemental oxygen is delivered as needed, usually by nasal canula (tubing placed in the nose to deliver oxygen). The patient's respirations are constantly monitored and should the patient become over-sedated, respirations are supported.

c. Administration of regional anesthesia.

i. The administration of regional anesthesia includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of regional anesthesia includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. Spinal or epidural catheter/medication is placed in the preoperative area, block room, or the operating room prior to surgery. In all instances, sterile technique is applied. Spinal, epidural and caudal blocks are referred to as regional or conduction block anesthesia. A spinal block is produced by the injection of a local anesthetic solution into the lumbar subarachnoid space (the space containing spinal fluid). An epidural block is produced with the injection of a local anesthetic into the epidural space usually at the lumbar or thoracic level that allows for a spread to get pain relief coverage in the area of surgical incision. A caudal block is performed by placing local anesthetic in the epidural space via a needle introduced through the sacral hiatus. For placement of spinal local anesthetic, the patient is usually placed in the sitting or lateral position. The vertebral level in which

the anesthetic is to be placed is determined. The patient's area of skin over the vertebral level to be injected is sterilely prepped with an antiseptic solution and draped. A small amount of subcutaneous local anesthetic is injected, to allow for the placement of the spinal needle. A spinal needle is placed between two spinous processes, and advanced through the supraspinous ligament, ligamentum flavum and dural matter). The needle is advanced until cerebral spinal fluid flows from the site of injection. This signals that the subarachnoid space has been entered, and the local anesthetic is then injected. After injection, the needle is removed. The patient is then laid down in the supine position. The patient's level of anesthetic (numbness) is assessed with pinprick, or ability to feel cold. The patient (if not in the operating room) is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, invasive monitors are also placed.

iv. For placement of epidural local anesthetic, or epidural catheter for the continuous delivery of local anesthetic, the patient is usually placed in the sitting or lateral position. The vertebral level in which the anesthetic is to be placed is determined. The patient's area of skin over the vertebral level to be injected is sterilely prepped with an antiseptic solution and draped. A small amount of subcutaneous local anesthetic is injected, to allow for the placement of the epidural needle. A common method for identifying the epidural space is the "loss of resistance" technique. An epidural needle is placed between two spinous processes, and advanced into the supraspinous ligament. After advancement into the ligamentum flavum, a glass syringe filled with air or sterile saline is attached. If the needle is correctly placed in the ligament, it will be difficult to inject the air or saline, and when the plunger is lightly pushed, it will "bounce back". The needle is advanced with continuous pushing on the plunger, until the air/saline has a sudden loss of resistance, signaling entrance into the epidural space. Local anesthetic can then be injected, or at this point, a catheter can be introduced through the needle, into the epidural space. The needle is then removed. The patient is then laid down supine. The patient's level of anesthetic (numbness) is assessed with pinprick, or ability to feel cold ice. The patient (if not in the operating room) is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, invasive monitors are also placed. The patient is sedated as in the case of moderate sedation as described above.

v. The administration of regional anesthesia includes the steps outlined in section (iii) of the above description of the administration of moderate sedation (MAC).

vi. Following the end of procedure, post-operative orders for blood pressure management, pain management, fluid management, and post-operative nausea management, are issued.[72] Possible complications of spinal block include hypotension (due to sympathetic nerve blockade and resulting venous pooling (widening of the veins which then hold more blood volume) and decreased venous return (decrease in blood return to the heart), or block of cardioaccelerator fibers (nerves that cause heart rate to increase) contributing to bradycardia (slow heart rate) and decreased cardiac output, post spinal headache, high spinal (which can result in inability to breathe or unconsciousness), nausea and vomiting, backache, or neurological sequelae/injury. Complications of epidural block are similar to those of spinal block, with the added risk of accidental dural puncture resulting in leak of spinal fluid and post dural puncture headache.

d. Administration of a peripheral nerve block.

i. The administration of a peripheral nerve block includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of a peripheral nerve block includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. A peripheral nerve block is placed by locating the peripheral nerve supplying the area involved with the surgery, sterile prep and drape of the area in which the block is to be placed. Delivery of an adequate amount of local anesthetic is made via a sterile syringe and needle to the area surrounding the peripheral nerve to be anesthetized. Location of the nerve is often performed with the use of an electrical peripheral nerve stimulator, or ultrasound. Examples of peripheral nerve blocks are median, radial, or ulnar nerve blocks for hand surgery, axillary nerve block for arm and hand surgery, femoral sciatic nerve blocks for knee surgery or amputation of the lower extremity, ankle block for foot or toe surgery. The patient's respirations are constantly monitored, and should they become over sedated, respirations are supported.

iv. The administration of a peripheral nerve block includes the steps outlined in section (iii) of the above description of the administration of moderate sedation (MAC).

19. The monitoring of general anesthesia, moderate sedation (MAC), regional anesthesia, or peripheral nerve block during a procedure includes the following:

a. The patient's oxygenation is continually evaluated. Methods of continual evaluation of the patient's oxygenation include the following:

i. Inspired gas (i.e. delivering gas to a patient so that the patient has an adequate level of oxygen). During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system is measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.

ii. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry (a device that shines two frequencies of light through skin and measures the percentage of hemoglobin carrying oxygen) is employed. When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm is audible. Adequate illumination and exposure of the patient are necessary to assess color.

b. The patient's ventilation is continually evaluated. Methods of continual evaluation of the patient's ventilation (ensuring the provision of both oxygen and carbon dioxide to a patient) include the following:

i. The patient's qualitative clinical signs are monitored such as chest excursion (the rising and falling of the chest), observation of the reservoir breathing bag (if a patient is breathing on his or her own, operating room personnel can observe the bag and see it move as a patient breathes) and auscultation (listening with a stethoscope to each side of the chest) of breath sounds. Continual monitoring for the presence of expired carbon dioxide is performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is often conducted.

ii. When an endotracheal tube or laryngeal mask is inserted, its correct positioning is verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis (amount of carbon dioxide that is expelled by the patient), in use from the time of endotracheal tube/laryngeal mask placement until extubation/removal or initiating transfer to a postoperative care location, is performed using a quantitative method such as capnography (a machine that measures carbon dioxide levels). When capnography is utilized, the end tidal carbon dioxide alarm is audible when necessary.

iii. When ventilation is controlled by a mechanical ventilator, a device is continuously used that is capable of detecting disconnection of components of the breathing system. The device gives an audible signal when its alarm threshold is exceeded.

iv. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation is evaluated by continual observation of qualitative clinical signs (such as chest wall movement and pulse oximetry readings), and/or monitoring for the presence of exhaled carbon dioxide.

c. The patient's circulatory function is continually evaluated. Methods of continual evaluation of the patient's circulatory function include the following:

i. Every patient receiving anesthesia is monitored with an electrocardiogram (machine that monitors for heart rate, heart rhythm, and heart ischemia), which continuously monitors heart function from the time that anesthesia is first administered until the patient leaves the operating room;

ii. Every patient receiving anesthesia has his or her blood pressure and oxygen saturation monitored and evaluated every five minutes during the administration of anesthesia; and

iii. Every patient receiving general anesthesia has his or her circulatory function continually evaluated during the administration of anesthesia by one or more of the following: taking a pulse, listening to heart sounds, monitoring a tracing of intra-arterial pressure, or pulse oximetry.

d. There must be the capability to continually monitor a patient's body temperature.

e. Additional invasive monitoring (i.e. central venous line or arterial line) may be used on the patient.[73]

f. If a general anesthetic is used and a physician is not a member of the operating team, a physician shall be immediately available in the hospital or an adjacent clinic to assist in emergency situations.<[74]

20. Following completion of the administration of anesthesia, the following care is afforded the patient:

a. The patient is evaluated.

b. The care of the patient is directly transferred to a qualified health care professional in the post-anesthesia care unit (PACU)/recovery room or the intensive care unit (ICU).<[75] Such professional must be capable of monitoring the patient's vital signs. The professional must also be capable of assessing the patient for pain, nausea/vomiting, and complications that can arise from surgery and anesthesia (i.e. hypertension, hypoxia, etc.). Should complications occur, the professional must immediately notify a physician. Such individual must also be trained to administer medications as required for analgesia, nausea/vomiting, or other indications.

c. Monitoring in the recovery area includes pulse oximetry, non-invasive blood pressure monitoring, heart rate monitoring, and invasive monitoring (arterial line, central venous line) as necessary.

d. The patient is assessed periodically for level of consciousness, pain complaints, and complications, should they occur.

e. The patient's vital signs and clinically relevant findings are documented in the patient's medical record.

21. After the following criteria are met, the patient may be discharged from the PACU or ICU:

a. The patient's vital signs are stable;

b. The patient's oxygen saturation levels are stable;

c. The patient's mental status has returned to the same mental status that the patient had prior to the procedure;

d. The patient's pain is being adequately controlled;

e. Any bleeding, nausea, or vomiting experienced by the patient is minimal; and,

f. There is resolution of the neuraxial blockade (the numbing caused by the spinal or epidural must wear off so that there is a return of function to the affected area of the patient's body).

22. If a patient is scheduled to leave the medical facility the day of the procedure, the patient may be discharged from the medical facility when the following additional criteria are met:

a. The patient can be discharged in the company of a competent adult; and,

b. The patient has received understandable instructions that explain the following:

i. Telephone numbers that the patient can use to contact a physician to discuss complications or questions about post-operative care;

ii. Instructions for medications prescribed and pain management;

iii. Information regarding the patient's follow-up visit; and,

iv. Information regarding the designated treatment hospital in case of emergency.

23. In some instances, particularly in rural areas, anesthesia is administered by a CRNA under the supervision of a non-anesthesiologist physician such as a surgeon. In such instances, while the non-anesthesiologist physician's role and responsibilities are comparable to the above described roles and responsibilities of anesthesiologists, the specific tasks reserved to the supervising physician and those assigned to the CRNA will vary by institution, by the normal practice of each supervising physician in that institution, and by the particular circumstances in each instance of anesthesia care.

a. In some instances where the CRNA does not have prescriptive authority, particularly in a rural area, a physician, APNP or other authorized prescriber may prescribe the anesthetic medications which are administered by the CRNA.

EXAMPLES OF EMERGENCY ANESTHESIA COMPLICATIONS

24. The following paragraphs set out how some representative emergency anesthesia complications would generally be managed by an anesthesiologist and a CRNA, AA or anesthesiology resident working under the direction of the anesthesiologist.

a. CRNAs who have successfully completed an accredited nurse anesthesia program have the education and training necessary to successfully and independently administer anesthesia and respond to the emergencies described in the following paragraphs.

25. For example. a 56-year old man undergoes an uneventful laparoscopic cholecystectomy (surgical removal of the gallbladder through a tiny incision at the navel). The patient's past medical history is significant for smoking, hypertension, sleep apnea (a condition in which patients have abnormal ventilatory patterns), and obesity. Ten minutes after arrival to the post-anesthesia care unit, the post-anesthesia care nurse/the intensive care unit nurse notices that the patient is tachycardic (the patient's pulse is too high at 110 beats per minute). The patient's oxygen saturation is 88% on 100% inspired oxygen by facemask (oxygen saturation is supposed to be approximately 93-100% on room air). The nurse then checks to make sure the monitor is on and the oxygen is on the patient. If the nurse finds that both the monitor and the oxygen are working correctly, the nurse will call an anesthesiologist or a non-anesthesiologist physician. The anesthesiologist and the physician will immediately come to the patient's bedside. Because of the high pulse rate and the low oxygen saturation, the patient is considered to have post-operative hypoxemia (low oxygen levels). The following sets out the differential diagnosis and treatment for post-operative hypoxemia. The likelihood of a successful outcome depends greatly on making a prompt and correct diagnosis.

a. The post-operative hypoxemia could be caused by airway obstruction, which most commonly occurs in the pharynx or the area behind the tongue. This diagnosis is made from the patient's known history of sleep apnea and physical exam, revealing obstructive breathing and a dulled mental status. In this situation, the anesthesiologist or other physician also needs to determine if the patient's condition is due to narcotics or residual muscle relaxation, both of which can worsen airway obstruction. Initial treatment of this problem involves tilting the head of the patient backwards and/or

manually moving the jaw forward until the obstruction is relieved. If the patient's condition is due to narcotics, the patient may need medication (Naloxone) to reverse the narcotics' effect. If the patient's condition is due to residual muscle relaxation, the patient will need additional medications to increase strength and muscle tone. In severe cases of airway obstruction, the patient will require assisted ventilation with a mask and/or reintubation. The patient will also need further observation to make sure that the problem does not recur.

b. The patient's post-operative hypoxemia could be caused by inadequate pain relief. If the patient complains of inadequate pain relief, treatment consists of the administration of more analgesic medication.

c. The patient's post-operative hypoxemia could be caused by atalectasis of the lungs (temporary collapse of lung segments, decreasing the lungs' ability to oxygenate the blood). This complication is common after this procedure, particularly in an obese person. This complication can also be caused by secretions and/or blood, which can plug airway segments and cause their collapse. Atalectasis of the lungs would be diagnosed by physical exam (decreased breath sounds at the lung bases) and chest x-ray (decreased lung volumes at the base of the lungs). To treat atalectasis, the patient is given humidified oxygen, repositioned into a sitting position, and encouraged to breathe deeply. If the patient does not improve, there are other, more serious problems that have to be considered as described below.

d. The patient's post-operative hypoxemia could be caused by a pneumothorax (air trapped in the chest cavity). Pneumothorax is a known complication of laparoscopy. Pneumothorax is diagnosed by physical exam (breath sounds are decreased on the affected side) and chest x-ray (air is identified in the space around the lung tissue). The treatment for pneumothorax depends on the size of the pneumothorax and the patient's condition. A small pneumothorax (less than 20% of the lung cavity) that is not compromising the patient's condition may be treated with oxygen and observation until it resolves on its own. A larger pneumothorax (greater than 20% of the lung cavity) usually requires insertion of a tube into the patient's chest; this tube over time drains the air and allows the lung to heal and re-expand. Most patients with a pneumothorax should be observed in an intensive care unit (ICU) until the pneumothorax resolves or shrinks significantly. If not diagnosed promptly, pneumothorax can progress to a life-threatening condition, tension pneumothorax, in which the trapped air acutely decreases blood flow to the lungs and the heart's ability to pump blood. The diagnosis of tension pneumothorax must be made quickly; treatment consists of rapid placement of a chest tube (as described above) or a large intravenous cannula into the anterior chest in order to relieve the pressure on the lungs and heart.

e. The patient's post-operative hypoxemia could be caused by coronary ischemia (not enough oxygen getting to the heart), leading to reduced blood flow from the heart and pulmonary edema (fluid on the lungs). Coronary ischemia is diagnosed by the patient's history (assuming the patient reports chest pain or other symptoms suggesting ischemia), a physical exam (rales, crackling sounds in the lung bases that suggest heart failure) and 12-lead electrocardiogram (ECG). The ECG done at this time needs to be compared to the ECG done on the patient before surgery. In this comparison, the physician looks for any changes suggestive of ischemia and impending damage to the heart. The initial treatments for coronary ischemia aim to increase oxygen supply to, and reduce oxygen demand from, the heart. Therefore, the patient typically receives supplemental oxygen and medications such as beta-blockers, which reduce oxygen demand, and nitrates, which reduce oxygen demand and improve oxygen supply. Depending on the patient's condition, invasive monitoring (arterial line, central line) might be needed. In addition, a cardiologist must be consulted as soon as possible. If the patient's condition improves, the patient is likely transferred to the ICU for observation. If the patient's condition does not improve, the patient may need emergency cardiac catheterization to diagnose and treat coronary blockages before a heart attack occurs.

f. The patient's post-operative hypoxemia could be caused by an asthmatic attack. An asthmatic attack would be diagnosed primarily by physical exam revealing tachypnea (fast breathing) and wheezing. The treatment for an asthmatic attack includes the administration of humidified oxygen, medications to improve airflow in the lungs (nebulized bronchodilators), and steroids for stabilization. If the patient's condition is severe, the patient may need epinephrine (adrenalin, which causes immediate relaxation of the airways), invasive monitoring (arterial line) with frequent blood sampling to measure pH, oxygen, and carbon dioxide), or possibly reintubation.

g. The patient's post-operative hypoxemia could be caused by aspiration pneumonia (stomach contents passing into the lungs). Aspiration pneumonia would be diagnosed by looking at the patient's history (an event in the operative period suggesting aspiration), physical exam (decreased breath sounds, rales or both), and chest x-ray (though this might not be clear in the immediate stages). Aspiration pneumonia, though rare, has high mortality if not treated aggressively and promptly. The treatment for aspiration pneumonia would include the administration of oxygen and steroids. The patient may also need intubation, bronchoscopy and lavage (flushing the lungs with saline solution), and observation in the ICU.

h. The patient's post-operative hypoxemia could be caused by a pulmonary embolism (blockage in the pulmonary blood vessels caused by a blood clot or air bubble). Pulmonary embolism is suspected in a patient when the patient experiences sudden rapid breathing, chest pain, shortness of breath, or pulmonary effusion (fluid on the lungs). The symptoms of pulmonary embolism are vague and overlap with those of asthma or heart failure. If a pulmonary embolism is suspected, the treatment can range from oxygen to reintubation and pharmacologic support of blood pressure.

26. For example, a patient undergoing plastic surgery is receiving local anesthesia via an injection into the chest and

develops symptoms such as shortness of breath, hypotension (a drop in blood pressure), or tachycardia (an unusually fast heartbeat). These symptoms might evidence one of a number of different causes, ranging from inadequate amounts of anesthesia, an allergic reaction to the anesthesia, a pulmonary embolus (a blood clot in the lung or injected air into a major blood vessel), surgical bleeding (bleeding resulting from the surgery itself or bleeding caused by an injection of anesthesia that interrupts a major artery), a hemothorax (i.e. a needle puncture of a major artery), or a pneumothorax (i.e. a punctured lung caused by a needle). Each potential cause indicates a different form of treatment. For example, the treatment for light anesthesia would be to deepen the anesthesia. The treatment for an allergic reaction to the anesthesia could include treating the patient with vasopressors, giving the patient fluids, or giving the patient adrenaline. If the patient stops breathing due to the allergic reaction, the patient must be resuscitated. The treatment for a pulmonary embolus would include supporting the patient's blood pressure and the placement of invasive lines. The treatment for a pulmonary embolus could also include the administration of drugs such as dopamine if a patient becomes hypotensive due to the pulmonary embolus. The treatment for surgical bleeding is to find the site of the bleeding and to stop the bleeding. The treatment for either a pneumothorax or a hemothorax would include insertion of a chest tube to either fill the lung or to drain the lung.

27. Patients whose hearts have been damaged from previous heart attacks may undergo surgical procedures involving blood loss, during which their blood pressure drops suddenly. When that happens, it must be determined what caused the drop in pressure. If the drop in pressure was caused by the drugs required to anesthetize the patient (some drugs are potent vasodilators or cardiac suppressants), the treatment may require administration of drugs which will raise blood pressure (vasoconstrictors to increase heart contractility or rate). If the drop in pressure was caused by the loss of blood, the proper response would be to rapidly administer fluid and blood. Treatment may also require the administration of drugs designed to raise the blood pressure. However, if the patient is actually suffering an attack of myocardial ischemia (inadequate oxygen to the heart), the proper response might not include the rapid administration of blood or the administration of drugs designed to raise the blood pressure. The proper response to an attack of myocardial ischemia would include optimizing the level of oxygen, decreasing stress on the heart, supporting blood pressure, and providing the patient with aspirin. If the course of emergency response is erroneously chosen (i.e. the patient is given blood or fluid when instead the patient should have received blood pressure or heart support), the heart may not be able to handle the influx of a large volume of fluid and may go into cardiac arrest.

CONCLUSIONS OF LAW

I. The Medical Examining Board has jurisdiction to decide this matter and has authority under Wis. Stat. § 227.41 to issue a declaratory ruling or to decline to issue a declaratory ruling.

II. Petitioner WSA has not shown that it is entitled to a judgment on its Motion for Summary Judgment as a matter of law.

III. The administration of anesthesia is part of the practice of medicine and surgery within the meaning of Wis. Stat. §§ 448.01 and 448.03(1).

IV. The administration of anesthesia is the practice of the practice of professional nursing within the meaning of Wis. Stat. §441.001(4)(intro).

V. A Certified Registered Nurse Anesthetist (CRNA) who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia is lawfully practicing within the scope of a certificate granted to practice professional nursing under Wis. Stat. ch. 441.

VI. A Certified Registered Nurse Anesthetist (CRNA) who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia, is practicing within Wis. Stat. § 448.03(2)(a), an exception to the general requirement for physician licensing in Wis. Stat. § 448.03(1)(a), and is not required to have a license as a physician or be supervised by a physician.

VII. A Certified Registered Nurse Anesthetist (CRNA) who is certified as Advanced Practice Nurse Prescriber (APNP) is required by Wis. Adm. Code § N 8.10(7) to work in a collaborative relationship with a physician.

VIII. A Certified Registered Nurse Anesthetist (CRNA) who is <u>not</u> certified as Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia, is practicing within Wis. Stat. § 448.03(2)(e), an exception to the general requirement for physician licensing in Wis. Stat. § 448.03(1)(a), and is not required to have a license as a physician, but is required to provide patient services, including administration of anesthesia, as directed, supervised and inspected by a physician.

Based on the record in this matter, the undersigned administrative law judge recommends that the State of

Wisconsin Medical Examining Board issue the following:

ORDER

NOW, THEREFORE, IT IS ORDERED That the Motion for Summary Judgment of the Petitioner Wisconsin Society Anesthesiologists shall be, and hereby is, DENIED;

IT IS FURTHER ORDERED That the Petition for Declaratory Ruling of the Wisconsin Society of Anesthesiologists shall be, and hereby is, DISMISSED.

/s/ William Dusso

William Dusso
Administrative Law Judge
Wisconsin Department of Regulation and Licensing
Dated: January 22, 2007

[1] Administrative rules of the BON define “advanced practice nurse’’ to include a registered nurse who has a current license to practice professional nursing and is currently certified by an approved national certifying body as a “certified registered nurse anesthetist.” "Nurse anesthetist" is defined in Wis. Stat. § 655.001(9) as “. . . a nurse licensed under ch. 441 . . . who is certified as a nurse anesthetist by the American Association of Nurse Anesthetists. Under Wis. Adm. Code § HFS 118.03 (27) "’Nurse anesthetist’ means a professional nurse licensed under ch. 441, Stats., who has obtained, through additional education and successful completion of a national examination, a certification as an anesthesia nursing specialist.” Other similar definitions are at Wis. Adm. Code § HFS 105.055(1), and 42 CFR 410.69(b).

[2] The rule was published on November 13, 2001 at 66 FR 56762. The regulations adapted and amended 42 CFR Parts 416, 482, and 485. The

full text of the *Federal Register* adopting these regulations is at Tab A to *Memorandum Of Petitioner In Support Of Motion For Summary Judgment* and Exhibit B of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*. As amended, the conditions of participation for hospital anesthesia services, for example, state as follows:

> TITLE 42--PUBLIC HEALTH
>
> CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)
>
> PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS . . .
>
> Subpart D--Optional Hospital Services . . .
>
> Sec. 482.52 Condition of participation: Anesthesia services.
>
> If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.
>
> (a) Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by--
>
> (1) A qualified anesthesiologist;
>
> (2) A doctor of medicine or osteopathy (other than an anesthesiologist);
>
> (3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
>
> (4) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or
>
> (5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.
>
> (b) Standard: Delivery of services. Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and post anesthesia responsibilities. The policies must ensure that the following are provided for each patient:
>
> (1) A preanesthesia evaluation by an individual qualified to administer anesthesia under paragraph (a) of this section performed within 48 hours prior to surgery.
>
> (2) An intraoperative anesthesia record.
>
> (3) With respect to inpatients, a postanesthesia followup report by the individual who administers the anesthesia that is written within 48 hours after surgery.
>
> (4) With respect to outpatients, a postanesthesia evaluation for proper anesthesia recovery performed in accordance with policies and procedures approved by the medical staff.
>
> (c) Standard: State exemption. (1) A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.
>
> (2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.

[3] The opt-out provisions are in 42 CFR §§ 416.42(d), 482.52(c), and 485.639(e). A copy of Gov Doyle's letter is Exhibit 1 to Petitioner's *WSA Exhibits Binder* submitted with Petitioner's *Memorandum Of Petitioner In Support Of Motion For Summary Judgment* and Exhibit C of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*.

[4]Acronyms used in this decision are:

AA - Anesthesiology Assistants.
AANA – American Association of Nurse Anesthetists.
APN - Advanced practice nurse.
APNP - Advanced Practice Nurse Prescriber.
BON – State of Wisconsin Board of Nursing.
CMS – U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services.
CRNA - Certified Registered Nurse Anesthetist.
CRNA/APNP - A Certified Registered Nurse Anesthetist who is certified by the Board of Nursing as an Advanced Practice Nurse Prescriber.
DHFS - State of Wisconsin Department of Health and Family Services.
DRL - State of Wisconsin Department of Regulation and Licensing.
MAC - Monitored anesthesia care.
MEB - State of Wisconsin Medical Examining Board.
PACB - State of Wisconsin Podiatry Affiliated Credentialing Board.
PACU - Post-anesthesia care unit.
RN - Registered nurse.
WSA - Wisconsin Society of Anesthesiologists.
WANA - Wisconsin Association of Nurse Anesthetists.
WSPM - Wisconsin Society of Podiatric Medicine.

[5] See Wis. Stat. § 806.04; 22A Am Jur 2d *Declaratory Judgments* § 1; *State ex rel. Chiarkas v. Skow*, 160 Wis. 2d 123, 131-132, 465 N.W.2d 625, 628 (1991).

[6] *Wisconsin Fertilizer Ass'n v. Karns*, 39 Wis. 2d 95, 107, 158 N.W. 2d 294, 300 (1968).

[7] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, at 2-5.

[8] *U.S. Oil Co. v. Midwest Auto Care Services, Inc.*, 150 Wis.2d 80, 86, 440 N.W.2d 825, 827 (Ct. App. 1989).
[9] 73 Am Jur 2d Summary Judgment § 1
[10] *Balele v. Wis. Pers. Comm'n*, 223 Wis. 2d 739, 745-46, 589 N.W. 2d 418, 421-22 (Ct. App. 1998).
[11] Wis. Stat. § 802.08(2); *Green Spring Farms v. Kersten*, 136 Wis. 2d 304, 315, 401 N.W.2d 816, 820 (1987).
[12] See *Strigenz v. Department of Regulation*, 103 Wis. 2d 281, 286, 307 N.W. 2d 664, 667 (1981); *Laufenberg v. Cosmetology Examining Board*, 87 Wis. 2d 175, 184, 274 N.W.2d 618 (1979).
[13] *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 188, 349 N.W. 2d 68, 76 (1984); *State ex rel. Wis. Registration Bd. of Architects & Professional Engineers v. T. V. Engineers*, 30 Wis.2d 434, 438-39, 141 N.W. 2d 235, 237 (1966).
[14] Wis. Stat. § 15.01(7) and 15.405 (7) and (7g).
[15] Wis. Stat. § 15.01(5)(b).
[16] Wis. Stat. § 227.10(1).
[17] Wis. Stat. § 440.035(1).
[18] Wis. Stat. § 440.045.
[19] "Affiliated credentialing board" is defined in Wis. Stat. § 15.01(1g).
[20] Wis. Stat. § 15.085(3)(b).
[21] *Flejter v. Estate of Flejter*, 2000 WI App 26, ¶10, 240 Wis. 2d 401, 409, 623 N.W. 2d 552, 557; *Georgina G. v. Terry M. (In the Interest of Angel Lace M.)*, 184 Wis. 2d 492, 512, 516 N.W.2d 678, 684 (1994).
[22] Wis. Stat. § 802.08. The procedure utilized for submitting and responding to proposed findings of fact is set forth in the *Second Amended Scheduling Order For Summary Judgment Motion* of July 25, 2006.
[23] Under Wis. Stat. § 448.01(9) the "practice of medicine and surgery" means:

> (a) To examine into the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality.
> (b) To apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions described in par. (a) and in sub. (2).
> (c) To penetrate, pierce or sever the tissues of a human being.
> (d) To offer, undertake, attempt or do or hold oneself out in any manner as able to do any of the acts described in this subsection.

[24] 2001 OAG #1-01; 68 Wis. Op. Att'y Gen. at 319-30 (1979). Overlap between the medical and nursing professions is also discussed in an opinion of the Texas Attorney General, 1999 Tex. AG LEXIS 136.
[25] 2001 OAG #1-01 10, 11.
[26] See: Wisconsin Department of Regulation and Licensing. Certification for Advanced Practice Nurses. January 17, 2006. http://drl.wi.gov/dept/forms/capn.pdf. (Copied as Appendix A).
[27] See Exhibit A, Affidavit of Francis Ross Gerbasi of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*.
[28] Wis. Stat. § 441.16; Wis. Adm. Code § 8.04. See also: Wisconsin Department of Regulation and Licensing, Advanced Practice Nurse Prescriber – Credentialing, January 18, 2007, http://drl.wi.gov/prof/nura/cred.htm; License Lookup Health Professions, January 18, 2006. http://drl.wi.gov/drl/drllookup/LicenseLookupServlet?page=lookup_health.
[29] Exhibits 10 - 39 to Petitioner's *WSA Exhibits Binder* submitted with Petitioner's *Memorandum Of Petitioner In Support Of Motion For Summary Judgment.*
[30] The rule specifying collaboration requirements of APNPs, Wis. Adm. Code § N 8.10 (7), was published in the Wisconsin Administrative Register, October, 2000, No. 538, eff. 11−1−00.
[31] *Wisconsin Administrative Register*, February, 1995, No. 470, eff. 3-1-95.
[32] See Appendix B. *Wisconsin Administrative Register*, September 1999, No. 525, 18. Moen and Nania letters are copied from the Department of Regulation and Licensing Rulemaking file for CR99-126.
[33] The legislative history of Clearinghouse Rule 99-126 is available at the Wisconsin Legislature Internet site *http://nxt.legis.state.wi.us/nxt/gateway.dll/?f=templates$fn=default.htm* under "BILL HISTORIES" for the 1999 legislative session.
[34] *Elections Bd. v. Wisconsin Mfrs. & Commerce*, 227 Wis. 2d 650, *597 N.W.2d 721* (1999); *Schoolway Transp. Co. v. DMV*, 72 Wis. 2d 223, 236-37, 240 N.W.2d 403 (1976); *Frankenthal v. Wisconsin Real Estate Broker's Board*, 3 Wis. 2d 249, 88 N.W.2d 352, reh'g den. 3 Wis. 2d 257A, 89 N.W.2d 825 (1958).
[35] *Mallo v. Wis. Dep't of Revenue*, 2002 WI 70 ¶30, 253 Wis. 2d 391, 417, 645 N.W.2d 853, 865.
[36] Wis. Adm. Code § 8.02(1)(b).
[37] Wis. Adm. Code § N 8.06(1).
[38] See Exhibits BON-2 (Affidavit of Linda M. Sanner, ¶1,), BON-3, and the "Clinical responsibilities checklist in BON-4.
[39] *Memorandum Of Petitioner In Support Of Motion For Summary Judgment,* 31-32.
[40] The BON contends that splitting the authority to prescribe from the authority to administer is impractical and would strain healthcare practice. *Board Of Nursing's Opposition To Petitioner's Motion For Summary Judgment*, 12-13.
[41] Page G24, Wisconsin Legislative Reference Bureau, Drafting Record for 1993 Wisconsin Act 138, copied under Tab F of the *Memorandum of Petitioner in Support of Motion for Summary Judgment.*
[42] *Memorandum of Petitioner in Support of Motion for Summary Judgment, 30-32.*
[43] Page F11, Wisconsin Legislative Reference Bureau, Drafting Record for 1993 Wisconsin Act 138. See Appendix C.
[44] "Statutory interpretation begins with the language of the statute. If the meaning of the statute is plain, we ordinarily stop the inquiry. Kalal v. Circuit Court for Dane County, 2004 WI 58, P45, 271 Wis. 2d 633, 681 N.W.2d 110. We assign the words in the statute their common, ordinary, and accepted meaning. Id. We also consider the context and structure of the statute. Id., P46. We interpret statutes to avoid absurd or unreasonable results and to give effect to every word in the text." *Olstad v. Microsoft Corp.*, 2005 WI 121, ¶18, 284 Wis. 2d 224, 234, 700 N.W.2d 139, 144.
[45] A CRNA/APNP is subject to the standards of professional conduct for registered nurses which, if violated, warrant disciplinary action,

including revocation and suspension. These standards prohibit acts which show the registered nurse, to be unfit or incompetent by reason of negligence. Wis. Stat. § 441.07(1)(c). For purposes of discipline the BON has defined "negligence" to mean: "Offering or performing services as a . . . registered nurse for which the licensee is not qualified by education, training or experience." Wis. Adm. Code § N 7.03(1)(intro) and (g). The Board's rules regulating APNPs provide in Wis. Adm. Code § N 8.05(3) that the APNP may "issue only those prescription orders appropriate to the advanced practice nurse prescribers areas of competence, as established by his or her education, training or experience."

[46] *State v. James P. (In re Chezron M.), 2005 WI 80,* P24-28, *281 Wis. 2d 68 Wisconsin Citizens Concerned for Cranes and Doves*, 2004 WI 40, 270 Wis. 2d 318, ¶17, 677 N.W.2d 612.

[47] See Stephen R. Miller, Legislative Reference Bureau, Wisconsin Bill Drafting Manual 2.01(1)(i) (2005−06).

<[48] Section 80, 2001 Wisconsin Act 107, states:

> Section 80. 441.11 (4) of the statutes is renumbered 441.001 (4) (intro.) and amended to read:
>
> 441.001 (4) ~~Practice of professional~~ Professional **NURSING.** (intro.) ~~The practice of professional nursing within the terms of this subchapter~~ "Professional nursing" means the performance for compensation of any act in the observation or care of the ill, injured , or infirm, or for the maintenance of health or prevention of illness of others, ~~which act~~ that requires substantial nursing skill, knowledge , or training, or application of nursing principles based on biological, physical , and social sciences, ~~such as the~~ . Professional nursing includes any of the following:
>
> (a) The observation and recording of symptoms and reactions ~~, the~~ .
>
> (b) The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if ~~that~~ the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state ~~, and the~~ .
>
> (c) The execution of general nursing procedures and techniques.
>
> (d) Except as provided in s. 50.04 (2) (b), ~~the practice of professional nursing includes~~ the supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants.

The note following section 80 of 2001 Wisconsin Act 107 states:

> **NOTE:** Moves definition section to the beginning of the subchapter, modifies language, and modifies language for improved readability and conformity with current style. The defined terms are changed to reflect the actual terms used in ch. 441. 1981 Wis. Act 317 added the phrase, "Except as provided in s. 50.04 (2) (b), the practice of professional nursing includes", in sub. (4) to exclude activity under that provision from the definition of professional nursing. The amendment of sub. (4) applies the phrase "professional nursing includes" to all of the examples under the subsection for consistency and to avoid possible confusion.

[49] 67 Cal. Op. Att'y Gen. 122, 1984 Cal. AG LEXIS 68.

[50] See responses and replies of the parties to *Petitioner's Proposed Summary Judgment Findings of Fact* ¶12.

[51] The definition of "professional nursing" in section 2725 of the California Nursing Practice Act quoted in the opinion states:

> "The practice of nursing within the meaning of this chapter means those functions including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problem or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all the following:
> "(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
> "(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
> "(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
> "(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."

[52] 1984 Cal. AG LEXIS 68 at 3.

[53] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, 28.

[54] Wis. Stat. § 441.16(3)(a).

[55] The legislature's findings in Section 1 of Act 37 were summarized in *State ex rel. Strykowski, v. Wilkie*, 81 Wis. 2d 491, 508; 533; 261 N.W.2d 434, 442 (1978).

> . . . The legislature cited a sudden increase in the number of malpractice suits, in the size of awards, and in malpractice insurance premiums, and identified several impending dangers: increased health care costs, the prescription of elaborate "defensive" medical procedures, the unavailability of certain hazardous services and the possibility that physicians would curtail their practices. In addition, resolution of a malpractice claim under the traditional tort litigation process has been found to require an average of nineteen months. . . .

[56] The provisions of Wis. Stat. ch. 655 (1975) were unsuccessfully challenged as unconstitutional in *State ex rel. Strykowski v. Wilkie,* 81 Wis. 2d 491, 261 N.W.2d 434 (1978). Although classification issues were raised as an equal protection challenge, the classification of physicians, hospitals and nurse anesthetists as health care providers is not discussed in the opinion. The court concluded generally: "We believe there is a rational basis upon which the legislature could and did act when enacting Chapter 655." *Strykowski,* at 508.
[57] 1993 Wisconsin Act 473.
[58] Current Wis. Stat. § 655.005 was created as Wis. Stat. § 655.004 (1985) by s. 26, 1985 Wisconsin Act 340.
[59] Wis. Stat. §§ 50.32 to 50.39.
[60] Wis. Adm. Code § HFS 124.20(2)(a)4.
<[61] Wis. Adm. Code § HFS 124.20(3)(b)3. – 5.
[62] Wis. Stat. § 15.085(3)(b): "The chairperson of an affiliated credentialing board shall meet at least once every 6 months with the examining board to which the affiliated credentialing board is attached to consider all matters of joint interest."
[63] CMS received over 28,500 comments on its proposed anesthesia requirements from hospitals, professional organizations, accrediting bodies, practitioners, and other individuals. 66 Federal Register 219 (13 Nov. 2001), 56703
[64] These findings were developed utilizing summary judgment procedures permitting a party to propose findings of fact and to contest proposed findings made by another party on the basis of admissible evidence. The procedure utilized for submitting and responding to proposed findings of fact is set forth in the *Second Amended Scheduling Order For Summary Judgment Motion* of July 25, 2006. These findings are based on agreement of the parties, the affidavits of Dr. Deborah Rusy and Dr. Brian G. McAlary and the conclusions reached in this decision regarding the responsibility of CRNAs. A proposed factual finding is included despite objections to the proposed finding if the proposed finding is material to the issues, consistent with the legal conclusions in this decision, and no supporting affidavits or other factual evidence is submitted to support the objection.
[65] The words "and prescription" as proposed by Petitioner were deleted from paragraph 3.a. based on the objection of the WANA and the discussion in the opinion regarding the respective authority of a CRNA/APNP and a CRNA not credentialed as an APNP.
[66] Paragraph 12.a. is based on the WANA's objection to Findings `12 – 23 and the affidavit of Dr. Brian G. McAlary, ¶ 5.
[67] Here, and generally, the assertion in the proposed findings submitted by the petitioner that the implementation of the anesthesia plan by a CRNA requires the CRNA to work under the direction of the anesthesiologist or that only an anesthesiologist may perform certain procedures is not included in these findings because the finding may be inconsistent with provisions of Wis. Stat. § 448.03(2)(a) and Wis. Adm. Code § N 8.10 (7) when the person administering the anesthesia is qualified as an APNP/CRNA.
[68] See Note 67.
[69] See Note 67.
[70] See note 67.
[71] See note 67.
[72] See note 65.
[73] See note 65.
[74] See note 65 and Wis. Adm. Code § 124.20(3)(b)5.
[75] See note 65.